DEPARTMENT OF HEALTH AND HUM[illegible] I SERVICES
CENTERS FOR MEDICARE & MEDIC[illegible]D SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G018	A. BUILDING _____ B. WING _____	04/06/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAXTER HOUSE	POST OFFICE BOX 621 KEEN MOUNTAIN, VA 24624

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS	W 000		

An unannounced annual Medicaid re-certification survey was conducted on 04/05/16 through 04/06/16. The facility was in compliance with the Federal ICF/ID regulations. The Life Safety Code will follow.

The census in this 12 certified bed facility was 10 individuals at the time of survey. The survey sample consisted of 4 current individual reviews (Resident's #1 through #4).

LABORATORY DIRECTOR'S OR PROVIOER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6I DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable t4 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.